Toronto Central **LHIN**

Healthier Communities, Stronger Health Care System

2008/09 Annual Report

Ontario
Local Health Integration Network

Contact Information

Telephone:

416.921.7453
1.866.383.5446

Email:

torontocentral@lhins.on.ca

Address:

425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4

Website:

www.torontocentrallhin.on.ca
www.lhins.on.ca/english
www.health.gov.on.ca/transformation/lhin/lhin_mn.html

ISSN 1911-3641 (Print) Annual report. Toronto Central Local Health Integration Network.
ISSN 1911-365X (Online) Annual report . Toronto Central Local Health Integration Network.

Table of Contents

Letter from the Chair

Mohamed Dhanani

On behalf of the Board of the Toronto Central LHIN, I am proud to share the LHIN's 2008/09 Annual Report. Change and progress, it has been said, take time but they also require impatience, and looking back at this past year, the LHIN has moved from planning to action on a number of fronts. And this action is producing results. The LHIN together with local health care providers and stakeholders have made measureable progress towards a health care system that is more accessible, accountable and equitable for the people we serve.

One particularly important achievement for the LHIN is in the area of health equity. We are Ontario's only "urban LHIN" responsible for arguably the most diverse city in Canada if not the world.

The make-up of Toronto brings with it diverse health care challenges. There are many statistics proving the relationship between social and economic inequities and poor health. Two numbers that have influenced the Toronto Central LHIN's thinking stand out: 1) diabetes is twice as high in low income versus high income neighbourhoods and 2) approximately 20 percent of seniors living in the Toronto Central LHIN have a mental illness. While we are seeing steady improvements in overall access to some health care services in our LHIN, we will not be truly successful until all people in our community benefit from better access and quality. On this score, we have a considerable way to go.

Health equity is a top priority of the Toronto Central LHIN Board. The Board Vice Chair, Dennis Magill, co-chaired a LHIN Health Equity Task Force which culminated in a Health Equity Discussion paper authored by Bob Gardner, Director of Healthcare Reform and Public Policy at the Wellesley Institute. This paper has been an important input to and guide for Toronto Central LHIN's health equity work. The 18 hospitals in our LHIN worked together to develop the first-ever Hospital Health Equity Plans. These plans document hospitals' current equity challenges and gaps and how they are reducing disparities and caring for those in greatest need. The information provides a crucial baseline for measuring and taking action on health equity. At least as important as data, is the level of commitment to equity within and across hospitals; a commitment that shines through in the quality and depth of the Health Equity Plans. The LHIN will use the plans to determine how to incorporate health equity into the next Hospital Service Accountability Agreements. And the plans will inform the LHIN's second Integrated Health Services Plan to be released in late 2009.

In 2008/09, the Toronto Central LHIN strengthened the Board by recruiting individuals who bring a wealth of public, private and not-for-profit sector expertise and experience. Our Board now has a full complement of nine members who reflect the diversity of Toronto and are determined to achieve a better health care system for the people who receive care in this city. The momentum underway in the Toronto Central LHIN is also a testament to the leadership and skills of the LHIN's CEO Matt Anderson and his staff team.

The Annual Report tells a story of the LHIN's evolution this past year. It recounts the actions of the Toronto Central LHIN and, most significantly, it reflects how the health care system is changing to better respond to all people's needs and contribute to healthier communities.

Mohamed Dhanani
Chair

Letter from the CEO

Matthew Anderson

2008/09 marked my first full year as CEO of the Toronto Central LHIN and I take great pride in being part of an organization on the move and a health care system that is improving care for millions of people who receive care in our LHIN.

While the LHINs are still relatively new to Ontario's health care landscape, I am struck by the impatience of consumers and health care providers for fundamental improvement in the performance of health care services. The Toronto Central LHIN shares this impatience.

The Annual Report highlights important improvements that have been achieved this year in the Toronto Central LHIN – many small and a few large. In my estimation, the most significant are: 1) shifting into action mode by concentrating on a select number of priorities; 2) strengthening the LHIN's performance measurement and management capabilities and; 3) incorporating the promotion of health equity into all or the Toronto Central LHIN's work.

Since my arrival at the LHIN, one of the pieces of advice that I receive most is to focus on a limited number of priorities and avoid the temptation of trying to solve all problems at once. Members of our community advise that the surest route to success is to zero in on the issues where we can have the greatest impact for the people we serve. To select our priorities for action, the LHIN looked at where there is a convergence between the provincial government's health care directions; local priorities from the first Integrated Health Services Plan; and the LHIN's accountability agreement with the Ministry of Health and Long-Term Care (MOHLTC). These are the actions we need to take now. And, they are the stepping stones for tackling other health care issues in the years to come.

In fall 2008, the Toronto Central LHIN developed a Roadmap for 2008/09 through to 2010/11 when the next Integrated Health Services Plan will come into effect. The LHIN identified three priorities – 1) Improving the performance of the system, of which the main strategy is reducing Emergency Room (ER) wait times and Alternate Level of Care days (ALC); 2) chronic disease management starting with diabetes; and 3) mental health and addictions. Community engagement, performance measurement and management and eHealth (the use of information technology to improve health care) are the key means by which we will accomplish these health system improvements.

In 2008/09, Toronto Central LHIN programs and projects directly benefited some 6,700 individuals and indirectly touched the lives of many more families, caregivers and communities. The LHIN led the implementation of two major health care initiatives, Aging at Home and the ER Pay for Results, designed to expand home and community-based care for seniors and to reduce ER wait times.

ER wait times began to steadily trend downward last year. While this is an early trend (data from April to December 2008), it reflects the concerted efforts being taken by all providers – community agencies, hospitals, Toronto Central Community Care Access Centre (CCAC) and long-term care – to tackle this pressing issue.

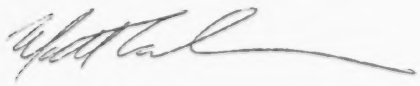
In 2008/09, all 18 hospitals in the Toronto Central LHIN signed Hospital Service Accountability Agreements (HSAA) and ended the year in a balanced position. Hospitals have committed to meeting clear and transparent quality improvement targets for the people they serve. At the same time, every hospital in the LHIN developed a Hospital Health Equity Plan, identifying equity issues and the steps that must be taken to reduce health care disparities in Toronto.

And 100 per cent of the LHIN's 149 community support service and mental health and addictions agencies signed their inaugural Multi-sector Service Accountability Agreements by March 31, 2009, a defining moment in the evolution of local community health services.

The Annual Report captures only a slice of the local health care achievements in the Toronto Central LHIN. I would like to acknowledge the exceptional care being delivered by organizations and individuals across the city that makes a difference in people's lives every day.

At the end of 2008/09, the Toronto Central LHIN is closer to becoming the kind of health care system our communities rightfully expect. But, there is much more work to be done. In the coming years we will confront an increase in the demand for health services together with uncertain new economic realities. As we work together to develop the LHIN's second Integrated Health Services Plan (2010-2013), this Einstein quote rings particularly true: "We can't solve problems by using the same kind of thinking we used when we created them."

Sincerely,

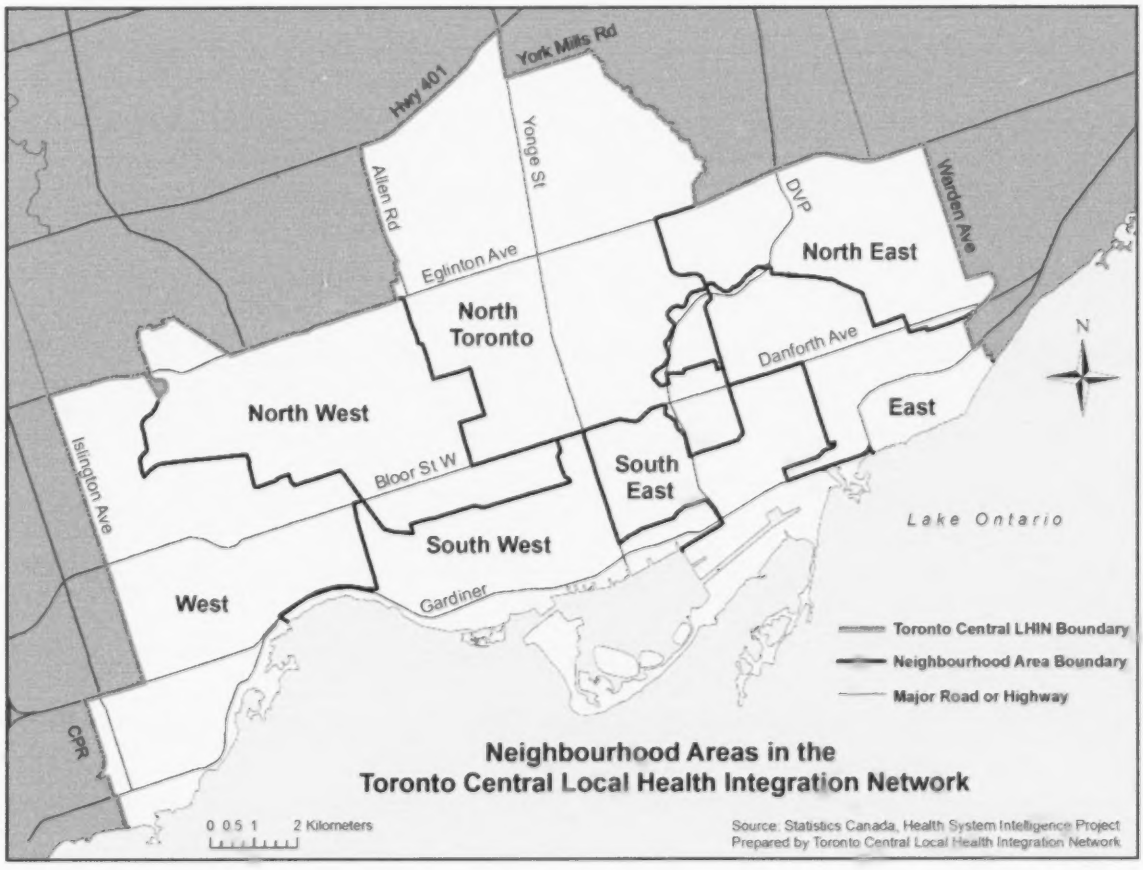


Matthew Anderson
CEO

Population Profile

Approximately 1,168,279 people – or 9.1 per cent of the population of Ontario (2007 population estimate) – reside in the Toronto Central LHIN. The population growth in our LHIN is, on average, slower than that of the province. From 1997-2007, the Toronto Central LHIN population grew, on average, by 0.7 per cent each year while the population of Ontario increased by 1.4 per cent annually during this same time.

As the only LHIN with its borders entirely within a major city, the Toronto Central LHIN is truly Ontario's "urban LHIN", and the rapidly increasing diversity of our population reflects that. More immigrants are choosing Toronto as their home than any other urban centre. In 2006, 41 per cent of Toronto Central LHIN residents were immigrants and 20 per cent of immigrants arrived between 2001 and 2006. Toronto Central LHIN residents come from all over the world (59 per cent of recent arrivals have come from East Asia and the Middle East. A smaller number have come from Eastern and Southern Europe and Africa (12, six and six per cent respectively)). This diversity is reflected in the variety of languages that are spoken in our city. More than 160 languages and dialects are spoken here. The top 10 most frequently spoken languages other than English are Chinese, Portuguese, Spanish, Italian, Tagalog, Greek, German, Urdu, Polish, and Russian. While English is still the dominant language, a minority (five per cent) do not speak English or French. About 23,000 people (two per cent) in the Toronto Central LHIN report that French is their first language.



Neighbourhood Areas in the Toronto Central Local Health Integration Network

The visible face of this LHIN is similarly varied. Of the total population, 32 per cent are visible minorities. The three largest groups in Toronto self identify as Chinese, South Asian or Black.

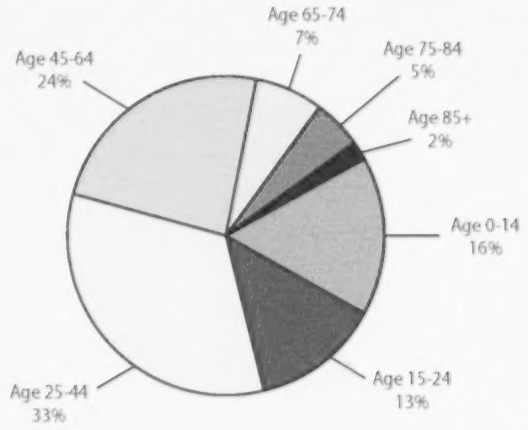
Further adding to the diversity of the population are differences in religion and sexual orientation. One out of 10 adults living within the boundaries of the Toronto Central LHIN is gay, lesbian, bisexual or trans-gendered (GBLT). GBLT people in the city have a higher incidence of health problems than the general population. These challenges include mental health issues, substance abuse, sexually transmitted diseases and some types of cancers.

Clearly, no two Torontonians are the same, and that diversity demands a flexible and inclusive approach to the delivery of health care within the LHIN.

Along with this rich diversity, there are considerable health inequities in the Toronto Central LHIN. For example, people living within the boundaries of our LHIN are less likely to suffer from some chronic diseases and are more likely to make healthier lifestyle choices than their counterparts in other LHINs. At the same time, Toronto Central LHIN residents with low incomes are more likely to report poor or fair health and to suffer from chronic diseases like diabetes and arthritis than those with higher incomes. Recent immigrants, Aboriginal peoples, single-parent families, children, people with disabilities and visible minorities are all over-represented in the low-income bracket. These groups all have distinct health care profiles that need tailored health care responses.

Aboriginal people, who make up about two per cent of the population of Toronto Central LHIN, are more likely to be younger, have low incomes, have limited education, be unemployed and head (or come from) a single-parent family

Table 2 – Toronto Central LHIN Population by Age, 2007



Total Population: 1,168,279
Males: 49%; Females: 51%
Age 65+: 155,071 (13%)
Age 75+: 79,058 (7%)
Age 85+: 21,347 (2%)

Source: Population Estimates 2007, PHPDB, MOHLTC

than the average LHIN resident. Aboriginal people are also over-represented among the homeless, those living with HIV/AIDS and addictions as well as victims of violence or injuries. As well, Aboriginal people have much higher rates of some chronic illnesses – diabetes, arthritis, depression, asthma and heart disease, than the non-Aboriginal population when age differences are taken into account.

Toronto has a significant homeless population with distinct health care challenges and needs. Three out of four (74 per cent) have at least one physical health condition and one in three (33 per cent) has been diagnosed with a mental illness.

By share of the population, seniors (65 and older) make up a significant group within the Toronto Central LHIN. More than 155,000 seniors (accounting for 13 per cent of the population) live here and that proportion is growing. It is growing particularly fast for older seniors (85 and older), who are nine times more likely

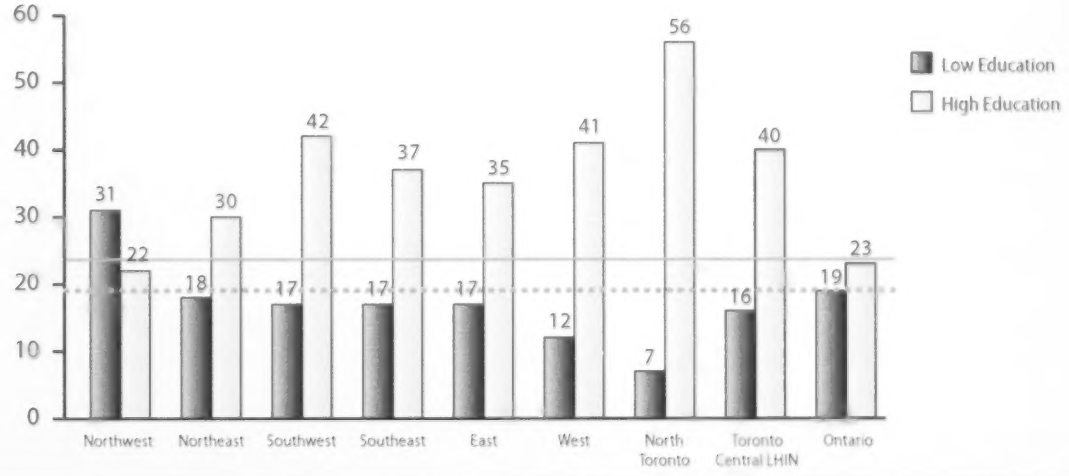
than younger seniors to live in a long-term care home or other institutional setting. Seniors make up 69 per cent of inpatient rehabilitation and 80 per cent of complex continuing care admissions in the Toronto Central LHIN. Also, 19 per cent of all ER visits to the Toronto Central LHIN and 32 per cent of acute hospital admissions are by seniors. One in 10 people in the Toronto Central LHIN are living with diabetes. That number climbs to 24.4 per cent of men 65 and over and 21.6 of women 65 and over. Perhaps most telling of all is the fact that seniors account for 77 per cent of patients who are considered "ALC" (individuals who are stuck in hospital beds waiting for discharge to more appropriate care including home care, supportive housing, rehabilitation and long-term care).

The Toronto Central LHIN is home to the lion's share of academic health science centres and highly specialized health care services in the province. It is also the location of the most intensive health and medical research in Canada. As a result of the specialized care delivered in the Toronto Central LHIN, more than half (55 per cent) of all acute hospitalizations and a third (35 per cent) of ER visits are by people who live outside the LHIN. And more than two thirds of specialized health care (heart procedures like bypass surgery and hip and knee replacements) provided was for residents of other LHINs.

Health Needs of Population

The Toronto Central LHIN community has a wide range of diverse health care needs. Chronic diseases and mental health and addictions represent two of the most pervasive local health issues. Chronic disease management demands ongoing and customized care, often for a person's entire life. Chronic disease is anticipated to grow in the Toronto Central LHIN as the population ages. More than one in three (31 per cent) of the residents have at least one chronic condition, including diabetes, some cancers, depression, arthritis, asthma, hypertension and chronic obstructive pulmonary disease (COPD). The two most common chronic diseases in the Toronto Central LHIN are arthritis and hypertension (affecting 13 and 12 per cent of adults respectively).

Table 3 – Education Levels Among Toronto Central LHIN Neighbourhood Areas, 2006



Almost 10 per cent of the population aged 20 and over (~86,000 people) is estimated to suffer from diabetes. In fact, 25 per cent of people with diabetes in Ontario live in Toronto Central LHIN. Diabetes is associated with many other chronic diseases. Of those diagnosed with diabetes, 76 per cent had at least one additional chronic condition, 42 per cent had two or more chronic conditions, 53 per cent had hypertension, 40 per cent had arthritis/rheumatism and 21 per cent had heart disease.

One out of four admissions to a hospital and one in 10 ER visits are caused by a chronic disease, as are one in five visits to a family doctor. A challenge for the LHIN is encouraging and supporting people to live healthier in order to reduce the incidence and impact of chronic diseases. Almost half of the adults in the Toronto Central LHIN are physically inactive and about 40 per cent are either overweight or obese. But health is not just about physical well-being.

One in 10 adult residents of our LHIN has experienced symptoms of mental illness (major depression, mania disorder, panic disorder, social phobia and agoraphobia) in the past year. Mental health issues do not affect all populations in the Toronto Central LHIN community equally: groups such as seniors, Aboriginal people, immigrants and the homeless experience higher rates of mental illness. Addiction often goes hand in hand with mental illness – a third (30 per cent) of people diagnosed with mental illness will also have an addiction, well above the rate for the rest of the community (10-20 per cent).

Meeting needs in these areas will not only enhance the health and quality of life of many people receiving care in the Toronto Central LHIN, it will improve the health care system and relieve the strain on health care providers. ER wait times and the number of people waiting in ALC beds are two key measures the Toronto Central LHIN will use to gauge how well the health care system is meeting the needs of the local population.

Community Engagement

LHINs were created specifically to improve the management of health care at a local level and enable Ontario's health care system to reflect the needs and priorities of the province's many disparate communities. For the Toronto Central LHIN, this means that health care needs and solutions are informed both by evidence and by the experiences and perspectives of various local communities – patients/clients, diverse ethno-racial groups, health care organizations, and health professionals.

Community engagement drives almost everything the Toronto Central LHIN does. The LHIN's core functions – strategy, planning, program development, performance measurement and management, project management and communications – all emphasize system transformation and are informed by the feedback the LHIN receives, and the understanding gleaned, from its communities.

As the LHIN moves forward with action in its priority areas, its approaches to engagement have also evolved. Following a 2008 review of the Toronto Central LHIN's formal engagement structures with members of the LHIN's Councils and Consumer Advisory Panels, the LHIN transitioned from Councils to Steering Committees for its priority areas: Mental Health and Addictions, Diabetes and Aging at Home. The Chairs of the former Mental Health and Addictions and Seniors Councils agreed to chair newly formed Steering Committees for these initiatives which had new mandates

geared to support implementation. The LHIN's Steering Committees are decision-focused, time-limited and involve consumer representatives.

The Joint eHealth Council continues to advise the Toronto Central and Central LHINs on eHealth initiatives within and across the LHINs. Other networks and health service providers in the Toronto Central LHIN are continuing the work begun by other Councils: Energy and Environmental Management, Rehabilitation, Health Human Resources, Education and Research, and Back Office Integration. For example, the GTA Rehabilitation Network is the Toronto Central LHIN's lead for policy and implementation related to local rehabilitation initiatives. The Chairs of the former Back Office Integration Council are leading Partnerships for Service Improvement (PSI), LHIN-funded demonstration projects to integrate back office and clinical support services among groups of hospital and community health service providers.

The LHIN is strengthening its four Consumer Advisory Panels – seniors, rehabilitation, mental health and addictions consumer and mental health and addictions family – through seeking member input into programs and actions in the LHIN's priority areas. In addition, panel members are assisting the LHIN to tap into the large web of consumer groups and networks within the city so that the LHIN can more effectively engage Toronto's diverse communities.

In winter 2009, the LHIN launched the Health Professional Advisory Committee, a committee of 13 health professionals representing nine disciplines that advises the LHIN on the design and implementation of health care initiatives from a clinical perspective. Also this past year, the Toronto Central LHIN created a Clinical Services Leadership Team (CSLT) – a team of clinical leaders representing different specialties including emergency medicine, critical care, oncology and family medicine. The CSLT reviews the LHIN's performance against targets and helps the LHIN to understand the clinical factors influencing issues such as wait times. CSLT members also promote performance improvement with their peers and organizations.

In addition to its formal engagement structures, the Toronto Central LHIN used the following approaches to engage its communities in 2008/09:

- customized strategies for reaching Aboriginal and francophone communities;
- working with community leaders and groups to reach into the diverse range of communities within the Toronto Central LHIN. Using techniques such as community animation whereby people from a specific community facilitate engagement sessions and seek input from community members where they meet and in their own language;
- surveys and focus groups;
- community development – the LHIN provides tools and supports to enable local communities and neighbourhoods to develop grassroots solutions to local health issues.

Equity and Engagement

The Toronto Central LHIN is always looking for new and better ways of expanding its reach into the diverse communities in our LHIN, including Aboriginal, francophone, ethno-cultural/linguistic and marginalized groups.

The LHIN used various targeted approaches to engage marginalized and under-served communities. Including:

Engaging People Living with Diabetes

Since being selected as a pilot site for the Ontario government's diabetes strategy in early 2009, the Toronto Central LHIN has been working to understand diabetes care from the perspective of people living with the disease and those on the front lines of diabetes prevention, care and research.

The LHIN's particular focus is on disadvantaged populations – specifically individuals living with diabetes who face barriers to health and social services; neighbourhoods with higher rates of diabetes and fewer resources; neighbourhoods with higher populations of new immigrants; and lower income households.

Created last year, the LHIN's Diabetes Steering Committee, chaired by Dr. Bernard Zinman, Mount Sinai Hospital, Lynne Raskin, South Riverdale Community Health Centre, and Dr. Lynn Wilson, University of Toronto brings together diabetes experts, community agencies and Canadian Diabetes Association to advise the LHIN on a team-based model for managing and treating people living with diabetes.

"Glad I came – felt like part of a group. Gave me motivation to take an active role in managing my disease."

– Individual with diabetes who attended the Toronto Central LHIN's diabetes forum, March 10, 2009

In early 2009, the LHIN also held six separate community-based focus sessions. This approach provided an intimate environment for people living with diabetes to talk about the barriers they face managing their disease, as well as what supports and services would make a positive difference. Each focus session averaged five – 40 people who ranged in age from 25 – 75 years. They represented a number of diverse communities including South Asian, Vietnamese, Caribbean and Spanish speakers, as well as seniors and individuals accessing the Ontario Disability Supports Program.

In addition, on March 10, 2009 the LHIN held a large public forum for people living with diabetes. Approximately 150 people attended and shared their views and insights through small group discussions.

In addition to the advice from the Steering Committee and primary care physicians, feedback received from people living with diabetes informed the Toronto Central LHIN's recommendations to the MOHLTC about primary care services for diabetes.

Aboriginal Engagement

Despite having the highest concentration of health service providers in Ontario, there is a disparity in the health status of Aboriginal peoples compared with the non-Aboriginal population in the Toronto Central LHIN.

A series of key informant interviews conducted throughout the Toronto Central LHIN in March 2008 indicated that Aboriginal engagement strategies should be undertaken on a GTA-wide basis given the distinct nature of urban Aboriginal issues. The unmistakable conclusion was that the GTA LHINs need to collaborate together and with Toronto-based Aboriginal groups in order to improve access to services for Aboriginal people in the GTA.

In early 2008, the Toronto Central LHIN joined forces with the four other LHINs that border the City of Toronto – Central, Central East, Central West, and Mississauga-Halton – to hold a forum on community engagement with local Aboriginals and agencies.

In addition, the LHIN sponsored a traditional community-wide feast , a venue for the LHIN Board and staff to gain a deeper understanding of Aboriginal culture and to foster mutual confidence and trust among Aboriginal community groups and the LHIN.

The Toronto Central LHIN also collaborated with Aboriginal agencies on a range of projects, including the development of the Aboriginal Diabetes Pilot Project work plan. Recently, the Toronto Central LHIN received one-time funding from Health Canada's Aboriginal Health Transition Fund (AHTF) in order to hire an Aboriginal Health Coordinator to provide coordination and direction in developing Aboriginal community engagement strategies for the city of Toronto.

Community Engagement	**Progress in 2008/09**
Diabetes Strategy	Engaged **24** organizations from different sectors **90** health professionals from across primary care and specialties **200** people with diabetes and their families through focus groups and Consumer Diabetes Forum. A group chaired by Joe Hester, Executive Director, Anishnawbe Health and representing different sectors, guided the development of a pilot for diabetes management in the urban Aboriginal community.

Anishnawbe Health Toronto is an Aboriginal health access centre and leader in urban Aboriginal health practices, combining primary care services, supportive programming and traditional medicine in order to address the physical, mental, spiritual and emotional needs of its clients.

Joe Hester is Anishnawbe Health Toronto's Executive Director, and a critical link to the Aboriginal community for the Toronto Central LHIN.

Hester indicated that diabetes is one of the major health concerns in Aboriginal communities, occurring at least three to five times more often in Aboriginal peoples than in non-Aboriginal peoples.

Hester added that achieving more positive results in prevention and management of diabetes would demand a major undertaking that would require GTA LHINs and service providers to work collaboratively for many years.

"We have to deal with the social determinants of health – poverty has a huge impact," he said. Hester also cites broad mental health concerns, particularly concurrent disorders, as being a high priority as well.

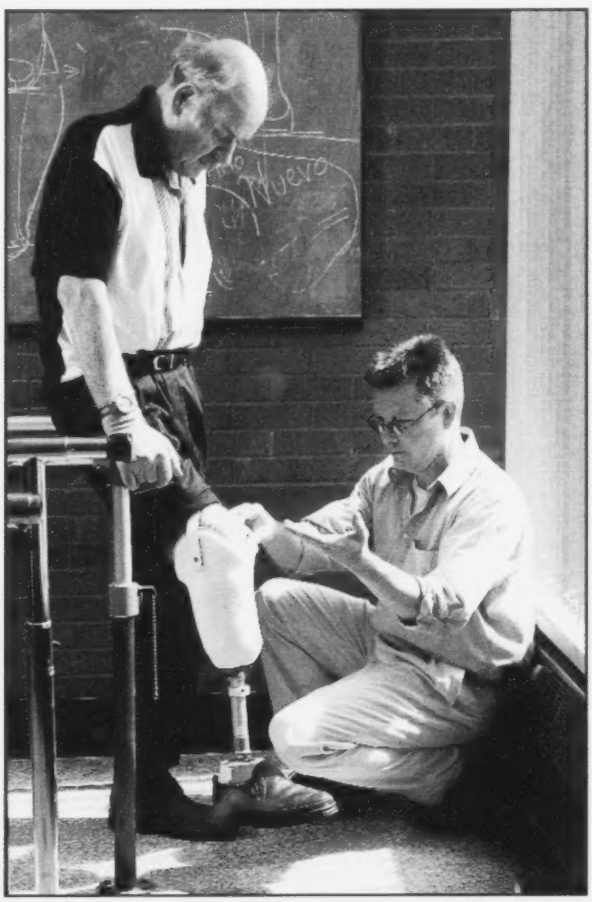
Additionally, the following proposals, submitted by the Toronto Central LHIN, were the successful recipients of AHTF funding last year:

- St. Christopher House – The Meeting Place – to run a healing circle to provide support for Aboriginal peoples with mental health and addictions who live on the streets
- Centre for Mental Health and Addictions (CAMH) – create and pilot an Aboriginal specific in-patient treatment program for people suffering from concurrent disorders
- Native Canadian Centre of Toronto (NCCT) – organize an urban Aboriginal health conference for Toronto, focusing specifically on diabetes and seniors

Francophone Engagement

Engaging with francophone communities is a key priority for the Toronto Central LHIN. The LHIN regularly engages local francophone agencies and other stakeholders through participation in the Toronto Region French Language Health Services Committee.

A critical step to enhancing health care services for francophones is to gain better information about francophone health care needs and services in and around Toronto. In 2008/09, the five GTA LHINs collaborated with francophone health service providers to create the first-ever integrated survey to assess French language services in all hospitals and community agencies. The survey identifies, for example, current gaps in access to French-speaking health professionals and specialty services. The survey results together with needs assessments conducted by local francophone agencies will provide a much fuller and more accurate picture of francophone health care needs. The LHIN will use this information to plan services and develop programs.



Evaluating Engagement

The Toronto Central LHIN continually reviews and assesses its approaches to community engagement. In 2007/08, the LHIN commissioned an external audit of our community engagement strategy and tactics compared to best practices. Going forward, the LHIN will evaluate our community engagement efforts using a common assessment tool which is being developed for all LHINs by Dr. Julia Abelson, Associate Professor in the Department of Clinical Epidemiology and Biostatistics at McMaster University. The tool will be ready for testing in summer 2009 and will fulfill the need for a consistent, evidence-based tool for all LHINs to benchmark and compare engagement practices.

Accomplishments in 2008-2009

In November 2006, the Toronto Central LHIN released its first Integrated Health Service Plan (IHSP). This three-year (2007-2010) plan was developed based on extensive community input and identified nine key areas for the LHIN. The IHSP has been the Toronto Central LHINs platform for action during its first two years.

During the summer of 2008, the LHIN Board and senior management team decided to accelerate action on a number of key IHSP initiatives. This decision was based on the idea that the LHIN needs to concentrate its energies and resources in a few key areas in order to have a more immediate impact on people's health care. A clear focus is essential when tackling a system as large, complex and resistant to change as health care.

The LHIN identified three priorities:

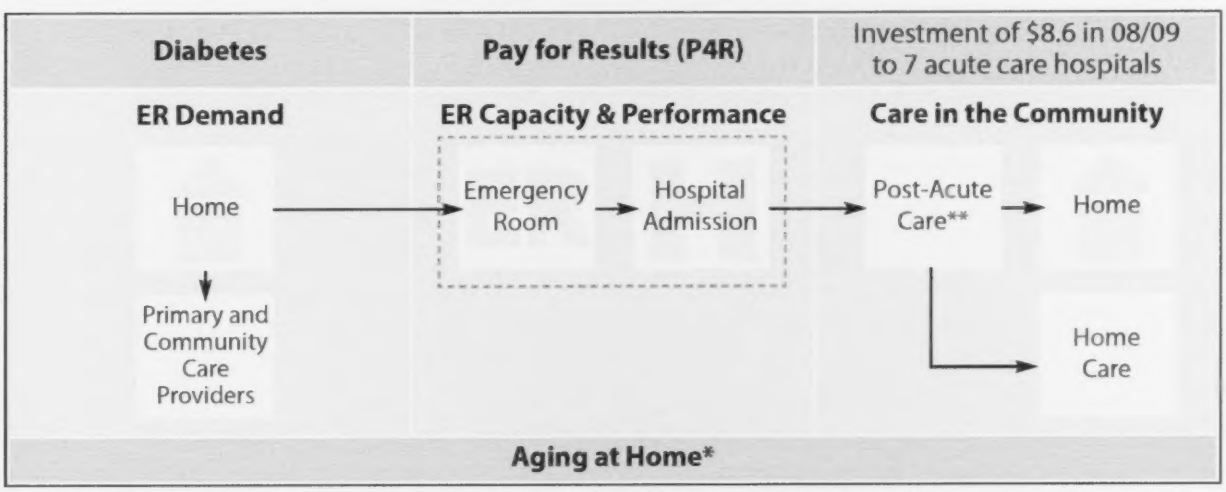
- Improving the performance of the system, of which the main strategy is reducing ER wait times and Alternate Level of Care days;
- Chronic disease management starting with diabetes; and
- Mental health and addictions.

Community engagement, performance measurement and management and eHealth are the key means by which we will accomplish these health system improvements.

Reducing ER Wait time and Alternate Level of Care

ER wait times is both a top government priority and a concern for the population who relies on access to ERs for medical emergencies. While the causes of long ER waits are complex, Alternative Level of Care (ALC) – a health care term that means patients are stuck in hospital beds waiting to be transferred to a more appropriate setting – is the greatest contributor to ER wait times in this LHIN. ERs become backed up when ER patients have to wait for hospital beds that are occupied by others who are waiting to be discharged. Three out of every four ALC patients are seniors. And a large

Emergency Room / Alternative Level of Care



$6.2 M in 17 Aging at Home projects to help seniors and at-risk populations to live healthy, independent lives in their homes and community.

* Includes Mental Health & Addictions investments

** Post-Acute Care Includes: Homecare Services, LTC, Rehab, CCC, Retirement Homes, Supportive Housing, Palliative Care, etc.

proportion of these are the most marginalized people in our city.

It is equally important to avoid ER visits altogether by preventing serious illness, promoting wellness and assisting individuals who are at-risk of ER admission, such as the frail elderly, to remain at home or in community care.

The Toronto Central LHIN is working with hospitals, the Toronto Central CCAC and community agencies to reduce ER wait times and improve people's access to the care they need outside of hospitals.

The Toronto Central LHIN's ER wait times and ALC reduction strategy has two main elements: the ER Pay for Results (P4R) program and the Aging at Home Strategy. Between April 2008 and February 2009, ER wait times progressively improved for patients with relatively minor and uncomplicated conditions and for those with more serious conditions requiring an admission to hospital. This improvement reflects the concerted efforts being taken by all providers to tackle this system-wide issue. Since the time period is relatively short, the LHIN needs to continue to closely monitor the direction of the trend and determine the impact of Aging at Home, ER Pay for Results and other investments.

ER Pay for Results (P4R) Program

The ER Pay for Results program provides financial incentives to seven hospitals to achieve ER wait time reduction targets. Last year, the MOHLTC allocated $8.6 million to Toronto General Hospital, Toronto Western Hospital, St. Joseph's Health Centre, St. Michael's Hospital, Sunnybrook Health Sciences Centre, Toronto East General and Mount Sinai Hospital.

In 2008/09, the first year of the ER Pay for Results program, hospitals primarily focused on improving the performance of ERs. Strategies included:

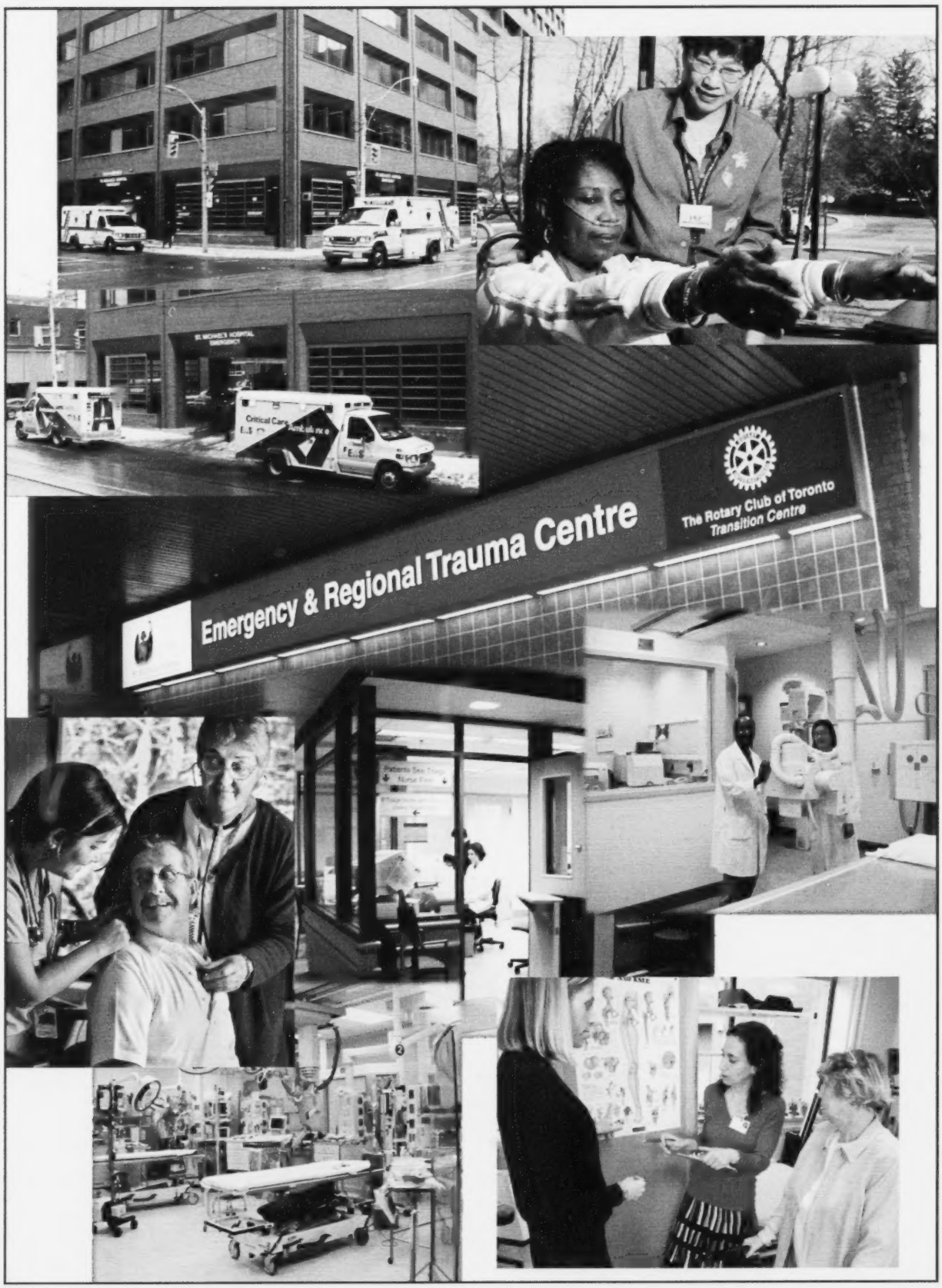
- Improving the flow of patients from the ER to other areas of the hospital and from hospitals to alternative settings such as home care and rehabilitation.
- Increasing the number of beds and other resources in the hospital
- Improving patient satisfaction by better understanding the patient's and family's experience in the ER and assisting staff to better respond to patient needs.
- Investing in critical infrastructure and IT to make the ER function better

Recognizing the importance of a "systems approach", the Toronto Central LHIN convened an Executive Committee comprised of the CEOs of the seven hospitals, the Executive Director of the Toronto CCAC, Toronto Emergency Medical Services (EMS) and the CEO of the Toronto Central LHIN to lead the development of an ER wait time action plan for the LHIN.

The ER P4R Executive Committee and working group identified collaborative initiatives designed to prevent unnecessary ER visits and help people to avoid premature institutionalization. One example is the nurse-led outreach teams in long-term care homes that will be rolled out across the Toronto Central LHIN in 2009/10. These teams of nurses travel to long-term care homes and provide intensive care to residents with urgent needs, avoiding unnecessary trips to the Emergency Room.

Aging at Home – Supporting Seniors to Live Healthy, Independent Lives

Last year, the Toronto Central LHIN provided $6.2 million to support 17 locally-driven


Emergency & Regional Trauma Centre
The Rotary Club of Toronto
Transition Centre

initiatives designed to expand access to home care, community services and supportive housing for older adults.

In its first year, Aging at Home initiatives directly benefited just under 2,500 seniors. And they are creating a ripple effect by improving the wellbeing of caregivers, families, and communities and generating new approaches to caring for older adults.

Not only are these programs assisting seniors to stay healthier and independent in their homes and communities, they are the key to helping seniors avoid hospitalization and ER visits.

The Aging at Home projects that started last year did 4 things:

- Supported better coordination of services for seniors,
- Expanded supportive housing,
- Enhanced access to Team Based Care; and,
- Promoted prevention and wellness.

Better coordinated services for seniors – These programs are removing barriers and matching seniors with care options that meet their individual needs. The Community Navigation and Access Project is an example. Led by Woodgreen Community Services with 33 community support service agency partners, this project developed an online library of community services available through the CCACs' Community Care Resources web site. The project's standard intake form is helping community agencies identify and assist frail seniors.

Expanded supportive housing – Last year, 301 more people received supportive housing services in the Toronto Central LHIN. These services provide extra support to seniors with complex challenges so they can stay in their home.

Enhanced access to team-based care – Aging at Home dollars supported specialized teams of health professionals to provide individualized care to seniors at risk of hospitalization. Mobile outreach teams provided by different Toronto agencies are helping seniors with mental health issues and other complex needs receive care in the comfort and dignity of their own homes.

Wellness/prevention – An important part of Aging at Home is helping seniors stay well and active. Last year, WoodGreen Community Services funded six grassroots projects that helped 1350 seniors. As part of this community development program, the Association for Spanish Speaking Seniors of the GTA educated Hispanic seniors about culturally sensitive prevention and care options for Alzheimer's, diabetes and cancer. Later in the Annual Report, you will read about the Flemingdon Health Centre's successful model for helping South Asian seniors manage diabetes.

Home at Last

Funded by the Toronto Central LHIN under the Aging at Home strategy, Home at Last (HAL), is designed to support seniors as they transition from hospital back home. Led by St. Christopher's House, HAL assists seniors who, with some additional support and assistance, are able to stay safely in their homes after being discharged from hospital. The program ensures that vulnerable older adults do not end up back in hospital or the ER because they haven't eaten properly, haven't taken their medications or have injured themselves.

Chronic Disease Management – Focus on Diabetes

A 2008 report by the Ontario Health Quality Council found that one in three Ontarians have one or more chronic diseases, such as diabetes, arthritis and heart failure. The Council also found that a staggering 60 per cent of Ontario's health care costs are due to chronic diseases. As mentioned earlier in the Population Health section, one out of four admissions to hospital and one in 10 ER visits are due to a chronic disease, as are one in five visits to a family doctor.

The number of Ontarians with diabetes has increased by 69 per cent over the last decade. Within the Toronto Central LHIN, approximately one in 10 adults are living with diabetes, representing over 90,000 people. Besides the sheer number of people affected, diabetes puts people at risk of significant disease and disability. Diabetes contributes to 32 per cent of strokes, 30 per cent of heart attacks and 70 per cent of amputations.

The provincial Diabetes Strategy was created to improve diabetes prevention and assist the growing number of people living with the disease. Given the Toronto Central LHIN's unique urban, multi-cultural setting, and high rates of diabetes and at-risk populations, it was selected last to be a pilot site for Ontario's Diabetes Strategy.

The LHIN received funding from the Ministry in December 2008 to:

- Create a map of current diabetes services and diabetes rates in the Toronto Central LHIN to expose gaps and inequities in accessing diabetes services;
- Engage with the LHIN's health service providers, health professionals and consumers to create options for improving access to primary care diabetes services, including making the most of existing local resources;
- Develop a work plan for a pilot project to improve diabetes management in the Aboriginal population. The Aboriginal diabetes pilot working group, chaired by Joe Hester, Executive Director, Anishnawbe Health Toronto, learned from diabetes care models for other ethno-cultural communities with high rates of diabetes, including Flemingdon Health Centre's Diabetes Prevention and Management Program;
- Provide recommendations for diabetes registry pilot sites and the LHIN's role in registry development. The registry is an electronic information system that will allow health professionals to keep track of and communicate with people with diabetes.
- In addition to consulting over 300 organizations, primary care physicians and other health professionals, and people with diabetes this past year, the LHIN established a Diabetes Steering Committee to provide expert advice on the implementation of the diabetes strategy. The LHIN's recommendations for increasing access to primary diabetes care, particularly for high-risk and underserved communities, is slated to be submitted to the MOHLTC in April 2009. Also in April, the LHIN will submit its plan for implementing the diabetes registry locally to eHealth Ontario.

Flemingdon Health Centre's South Asian Diabetes Prevention Program

This innovative program is focused on diabetes prevention, education and management for South Asian seniors in Toronto's north east region. The South Asian Diabetes Prevention Program (SADPP) builds on and expands the Mid-Toronto Diabetes Education program at Flemingdon Health Centre, allowing it to offer culturally relevant diabetes detection and management services in five different languages. SADPP has a team consisting of a Registered Nurse, Registered Dietician, Project Coordinator, Project Manager and three outreach workers. As Neil Stephens, SADPP's project coordinator explains: "This program reaches out to the South Asian communities where members are tied by their affinity to languages such as Tamil, Farsi, Urdu, Gujarati, Hindi and Bengali. We cut across religious lines by visiting mosques, temples, churches and community centres, within the Flemingdon Health Centre catchment area."

Caregiver and client at Flemingdon Health Centre

The program provides a range of services including outreach (as described above), information sessions, monthly voluntary screening, identification of pre-diabetic and high-risk groups, diabetes management plans based on South Asian diets, and caregiver workshops. Since the SADPP began in January 2009, 88 seniors have been screened for diabetes and 70 have attended educational workshops. In the coming year, it is anticipated that more than 650 seniors will benefit from Flemingdon's diabetes education and screening sessions.

Mental Health and Addictions

Improving the accessibility and equity of mental health and addictions services is an immediate priority for the Toronto Central LHIN.

One in 10 adults living in the Toronto Central LHIN has experienced a mental illness in the past year. This number rises sharply among certain populations such as seniors, with 20 per cent of Toronto Central LHIN residents aged 65 and over living with a mental health issue. People who are homeless or living in poverty have a high rate of mental illnesses and/or addiction compared with the general population.

Mental illness and/or addictions account for eight per cent of ER visits, with a high rate of return visits. People diagnosed with mental illnesses and/or addictions account for 11 percent of ALC in acute care – mainly due to older adults suffering from psychogeriatric issues like dementia who are waiting for long term care.

Last year, the Toronto Central LHIN invested in various initiatives to support people living with mental health and addictions issues including:

- Expansion of supportive housing;
- Outreach services to support seniors with mental illness and/or addictions to remain in the community and avoid crises;
- A standard processes for client intake and referrals, starting with supportive housing for people with mental illness and/or addictions. This initiative is key to removing disparities among clients and raising overall access to mental health and addictions services;
- Expanding an electronic medical record for the homeless population called Client Access to Integrated Services and Information (CAISI);
- Development of a transitional unit to support seniors who are hospitalized with mental health issues to prepare for a return to the community;
- Specialized tools and education materials to help ER staff to identify and assess seniors in ER with mental health and addictions issues, and link these clients with appropriate post-ER care.

Of the 301 clients served by the new supportive housing units created in the Toronto Central LHIN, approximately 150 suffer from mental illness and/or addictions, including dementia and related conditions.

By the end of March 2009, 37 mental health and addictions agencies were using the CAISI electronic health record for the homeless and 3,946 homeless clients across the city were supported through this system.

Thirty-two mental health and addictions agencies from Toronto Central and other GTA LHINs are participating in the project to coordinate client access to supportive housing.

If the Toronto Central LHIN is able to improve the health care experience of people with mental health and addictions issues, it will go a long way in transforming the health care system for all people in the LHIN.

Supporting Strategies

Health Equity

Health equity is woven into everything that the Toronto Central LHIN does. This commitment to health equity extends from our Board throughout the organization. The LHIN recognizes that the only way to achieve a healthier community and an affordable health care system for all is by addressing disparities in access to needed

health care services for poor and marginalized individuals.

A growing body of evidence shows that disadvantaged and marginalized people have both the greatest health care needs and the worst health outcomes.

The statistics are striking:

- The incidence of diabetes is twice as high in low income versus high income neighbourhoods;
- Immigrants to Canada are more likely to have cardiovascular disease which is worsened by language and other barriers to getting appropriate health care in addition to lifestyle, diet and other factors related to the stress of settling in a new country;
- More low income people are living with pain and disability because they are receiving 60 per cent fewer hip replacements than people with higher incomes.

In July 2008, Bob Gardner, Director of Healthcare Reform and Public Policy for the Wellesley Institute, submitted a Health Equity Discussion Paper for the Toronto Central LHIN that sets out key actions to promote health equity. The LHIN took action on three key areas in the paper this past year:

- building equity into service provision;
- making investments and interventions that will have the greatest impact on equity;
- embedding equity into our interventions to change the health care system in the LHIN.

The Toronto Central LHIN worked with the Hospital Collaborative on Marginalized Populations drawn from the LHIN's 18 hospitals to develop Hospital Health Equity Plans. This is the first time hospitals in the Toronto Central LHIN and, in fact, anywhere in Ontario, has been asked to document their equity challenges, gaps, practices and improvement plans. All 18 hospitals submitted plans that were signed by hospital CEOs and Board chairs, signifying a commitment at the highest levels to the health equity cause. The LHIN is working with partners the Wellesley Institute and the Centre for Research on Inner City Health (CRICH) at St. Michael's Hospital to analyze the plans over the summer. A range of stakeholder dialogues in July and August will shed more light on the results and inform the final report and next steps. The LHIN will consider how it can incorporate health equity into the next Hospital Service Accountability Agreements and the findings will inform the next Integrated Health Services Plan (2010-2013).

Last year, the Toronto Central LHIN partnered with the Ministry of Health and Long-Term Care's Health Equity Branch to develop a Health Equity Impact Assessment Tool that can be used by the LHIN and health service providers to assess the impact of decisions and investments on different populations.

The June 2008, the Healthy Connections 2008 conference, sponsored by the Toronto Central LHIN, brought together front-line workers, administrators, policy-makers, consumers and families to learn about the realities of health inequity as well as strategies for creating a more inclusive and just local health care system.

eHealth

Delays in transitioning clients from one level of care to the next are due in large measure to the fact that historically referrals have been based on relationships between providers (or "who you know") and assumptions about admission criteria and appropriateness of services rather

than real-time, comprehensive information about available services.

Over this past year, the Toronto Central LHIN harnessed the power of health information technology to address these delays and build a safer, more efficient and modern health care system.

The Toronto Central and Central LHINs partnered on a joint three-year eHealth strategy in 2007, reflecting the proximity between these neighbouring LHINs and similarities between the communities they serve. As part of this joint strategy, the Toronto Central LHIN launched two key eHealth programs that are changing the way health care is delivered to local residents.

Resource Matching and Referral (RM&R)

Improving client/patient referrals and flow from one part of the health care system to the next is a central element of the Toronto Central LHIN's strategy to reduce ER wait times and ALC days.

Resource Matching and Referral (RM&R), an electronic referral system, will transform the referral process by linking patients/clients with available services based on a standardized assessment of the patient's needs.

A key element of the LHIN's effort to reduce ER wait times, ALC and develop eHealth strategies, RM&R will reduce ALC by moving more patients more rapidly out of hospital beds and into the level of care that best meets their individual needs.

RM&R also provides powerful information for health system planning. The system identifies who is waiting, where they are waiting, and inconsistent referral and admission practices from one organization to the next. The system will enable the LHIN to tackle health inequities by identifying hard-to-place patients/clients and to ask critical questions of health service providers that restrict access to certain types of patients/clients. RM&R will give the LHIN reliable facts that it can use to address gaps and bottlenecks within and between organizations.

The Toronto Central LHIN used its Urgent Priority Funds to expand the system in 2008/09.

As of March 2009, RM&R is being used in six acute care facilities and eight rehabilitation and complex continuing care facilities (Rehab/CCC), the Toronto Central CCAC and 12 long-term care homes within our LHIN. The groundwork is also being laid for implementing RM&R in mental health, addictions and community support service agencies across the LHIN starting in 2009/10.

ConnectingGTA – Health Information and Access Layer (HIAL) and Provider Portal

ConnectingGTA is a joint initiative of the five GTA LHINs (Toronto Central, Central, Central East, Central West, Mississauga-Halton) to deliver a healthcare information exchange solution for providers across the GTA. The system developed is dubbed HIAL – an information technology that links different data systems and sources such as patient or disease registries, lab results and drug information. The Provider Portal provides primary care physicians and other health professionals with user-friendly access to vital health information about their patients/clients.

The Toronto Central LHIN worked with the other GTA LHINs to identify the business, technical, privacy and governance requirements associated with the HIAL and Provider Portal.. Over 46 GTA health service providers, 20 clinicians, including physicians, pharmacists, nurses, and physiotherapists, and experts from other jurisdictions were engaged in the development of these requirements.

HIAL is a key component of an Electronic Health Record that is being developed in Ontario.

A 3-year business case and early release plan has been submitted to eHealth Ontario for implementation approval.

Driving Health System Performance Improvement and Accountability

One of the LHINs' central roles is to continually improve the performance of the local health care system. This role is set out in the Local Health System Integration Act, 2006. It is the foundation of the LHIN's accountability agreement with the Ministry of Health and Long-Term Care (MOHLTC) – the Ministry LHIN Accountability Agreement – and the accountability agreements between the LHIN and the health service providers it funds., The Toronto Central LHIN developed a comprehensive performance management program in 2008/09 to put this concept into action.

It involves working with the MOHLTC and other partners to identify and refine performance indicators for the LHIN and its health service providers. This past year the LHIN also developed tools to analyze, report and, most importantly, use information to improve local health system performance.

Four times a year, the LHIN's Board reviews a scorecard on the overall performance of the LHIN and individual health service providers. A Clinical Services Leadership Team, made up of recognized leaders from different health professions, provides clinical insights about the results. The LHIN works with hospitals who are not meeting performance targets to uncover and resolve underlying issues.

In 2008/09, 100 per cent of the LHIN's hospitals signed Hospital Service Accountability Agreements (HSAA) and ended the year in a balanced position.

Each of the 149 diverse community support service and mental health and addictions agencies and the Toronto Central CCAC signed accountability agreements with the LHIN, committing to a new standard of accountability and transparency.

In 2008/09, the Toronto Central LHIN met or exceeded its performance targets for the majority of performance indicators. The LHIN's strong performance reflects the tremendous level of dedication, creativity and collaboration between the LHIN and health service providers. Key highlights:

- In 2005/06, the Toronto Central LHIN's average wait time for hip replacement surgery was 296 days compared with 114 in 2008/09 – a 61 per cent decrease.
- In 2005/06, knee replacement surgery wait times were approximately 393 days compared with 122 days in 2008/09 – a 69 per cent decrease.

The LHIN's Hip and Knee Central Intake Model continues to play an important role in reducing our wait times in this area. The model was created to manage the multiple bookings made at hospitals in order to streamline the patient referral process, and thereby shorten wait times for patients.

The LHIN's Diagnostic Imaging (DI) Network is another key initiative contributing to lower wait times. This Network brings together clinicians and administrators from hospitals to share best practices.

- For MRI scans, the Toronto Central LHIN's average wait time was 93 days in 2008/09 – down from 101 days.
- For CT scans, the Toronto Central LHIN's average wait time was 50 days in 2008/09 – down from 82 days.

Table 1 – Toronto Central LHIN MLAA Performance Indicators 2008/09

Performance Indicator	Starting Point	Target	Most Recent Quarter*	Annual Results**	Met Target (Yes/No)
90th Percentile Wait Times for Cancer Surgery	68	57	65	66	NO
90th Percentile Wait Times for Cardiac By-Pass Procedures	52	42	50	50	NO
90th Percentile Wait Times for Cataract Surgery	115	105	105	104	YES
90th Percentile Wait Times for Hip Replacement	124	124	125	114	YES
90th Percentile Wait Times for Knee Replacement	136	128	137	122	YES
90th Percentile Wait Times for Diagnostic MRI Scan	101	89	98	93	YES
90th Percentile Wait Times for Diagnostic CT Scan	82	68	48	50	YES
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)	242.91	241.00	236.31	232.50	YES
Median Wait Time to Long-Term Care Home Placement -All Placements	100.00	77.00	94.00	89.00	YES
Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution	10.00	9.43	9.49	10.20	YES
Rate of Emergency Department Visits that could be Managed Elsewhere	8.39	8.10	8.04	7.89	YES
Readmission Rates for Acute Myocardial Infarction (AMI)	2.84	2.70	2.99	2.89	YES

Note:

* Performance indicators 1-7 = Q4 2008/09; and 8-12 = Q3 2008/09

** Performance indicators 8-12 (in the Annual Results Column) only include the average of Q1-3

Creating an Integrated Health Care System

Partnerships for Service Improvement (PSI)

In February 2009, the Toronto Central LHIN launched Partnerships for Service Improvement. The goal of PSI is to create a more efficient health care system and reduce costs by supporting health service providers to partner on initiatives to integrate back office (i.e., human resources, information technology, and legal) and clinical support (i.e., pharmacy) services.

PSI is co-chaired by Rob Devitt, CEO of Toronto East General Hospital and Brigitte Witkowski, Executive Director of Mainstay Housing. Through PSI, the LHIN will provide seed funding for five initial demonstration projects (selected though independent peer review), which in turn, can be replicated or expanded on a broader, LHIN-wide scale.

Integrating back office services is not new to health care. Many health service providers within the LHIN have formed successful partnerships to realize savings and improve care delivery. For example, five local hospitals – Mount Sinai Hospital, Toronto General Hospital, Toronto Western Hospital, Princess Margaret Hospital and Women`s College Hospital – created a Joint Department of Medical Imaging.

Voluntary Integrations

Voluntary integrations – those that are initiated by two or more health service providers – are an important strategy for improving the coordination, accessibility, quality and efficiency of health services. In 2008/09, the Toronto Central LHIN passed motions in support of four voluntary integrations involving community support service agencies and hospitals.

Council of Academic Hospitals of Ontario (CAHO) Capital Equipment Group Purchasing Initiative	Nine acute care and rehabilitation hospitals piloted a group purchasing process for capital equipment designed to cut costs and duplication.
WoodGreen Community Services merger with Meals on Wheels East Toronto	Merger aimed at improving access to food programs for seniors, food service delivery, nutrition programming, and efficiencies by consolidating administration, streamlining operations.
WoodGreen Community Services merger with Jack McCreadie Towers Services	Merger aimed at improving coordination of services and the cultural and linguistic competency of programs for the Chinese community, and increasing the volunteer network.
Toronto Rehab and St Joseph's Health Centre	Transfer an in-patient rehabilitation unit from St. Joseph's Health Centre to Toronto Rehab, enabling patients to benefit from shorter hospital stays and access to the expertise and leading practices available at a teaching hospital specializing in rehabilitation.

Conclusion

2008/09 was a year in which the Toronto Central LHIN transitioned from planning to action.

Together with local community members and health care providers, the LHIN began laying the foundation for a more equitable health care system that responds to the needs of socially and economically disadvantaged community members.

There was a new level of collaboration among hospitals, long-term care and community agencies. The LHIN and health service providers continued to build bridges with primary care providers who are pivotal to the local health care system and, specifically, to improving the health of seniors, and people with mental illness and/or addictions and diabetes.

The progress made this past year is the result of the efforts and steadfast leadership of the LHIN's dedicated Board of Directors and 30 skilled and hard working staff, and, of course, the multitude of health care providers, workers, community members and advocates who form the Toronto Central LHIN's health care community.

Our Board of Directors

Name	Position	Appointed	End of Current Term	Length of Term
Coyles, Stephanie	Director	29 October, 2008	28 October, 2011	3 years
Dhanani, Mohamed	Chair	7 March, 2007	1 June, 2009	2 months 2 years
Everett, Barbara	Director	17 May, 2006 16 June, 2007	16 June, 2007 15 June, 2010	13 months 3 years
Ewart, Bonnie	Secretary	17 May, 2006 16 June, 2007	16 June, 2007 15 June, 2010	13 months 3 years
Kennedy, Tom	Director	27 June, 2007 27 June, 2008	26 June, 2008 26 June, 2011	1 year 3 years
Komori, Lloyd	Director	21 August, 2008	20 August, 2011	3 years
Magill, Dennis	Vice-Chair	7 March, 2007	6 March, 2010	3 years
Nott, Harley	Director	2 June, 2005 2 June, 2008	1 June, 2008 1 June, 2011	3 years
Virmani Kumar, Anju	Director	14 May, 2008	18 May, 2011	3 years

The aggregate remuneration for members of the board of directors for fiscal year 2008-2009 was $145,950.

Stephanie Coyles
Director

Mohamed Dhanani
Chair

Barbara Everett
Director

Bonnie Ewart
Secretary

Tom Kennedy
Director

Lloyd Komori
Director

Dennis Magill
Vice-Chair

Harley Nott
Director

Anju Virmani Kumar
Director

Deloitte

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Auditors' Report

To the Members of the Board of Directors of the
Toronto Central Local Health Integration Network

We have audited the statement of financial position of the Toronto Central Local Health Integration Network (the "LHIN") as at March 31, 2009 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Toronto Central Local Health Integration Network as at March 31, 2009 and the results of its operations, its changes in its net debt and in its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 5, 2009

Toronto Central Local Health Integration Network

Statement of financial position
as at March 31, 2009

	2009	2008
	$	$
Financial assets		
Cash	**1,857,932**	2,427,507
Due from Local Health Integration Networks ("LHINs") (Note 3)	**272,897**	68,649
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding HSP transfer payments	**10,855,983**	6,041,877
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Note 4b)	**-**	355,037
	12,986,812	8,893,070
Liabilities		
Accounts payable and accrued liabilities	**2,132,555**	2,853,246
Due to HSPs	**10,855,983**	6,041,877
Due to MOHLTC (Note 4b)	**550**	-
Deferred revenue	**25,950**	-
Deferred capital contributions (Note 5)	**985,319**	1,233,677
	14,000,357	10,128,800
Net debt	**1,013,545**	1,235,730
Non-financial assets		
Prepaid expenses	**28,226**	2,053
Capital assets (Note 6)	**985,319**	1,233,677
	1,013,545	1,235,730
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

Toronto Central Local Health Integration Network

Statement of financial activities

year ended March 31, 2009

	Budget (unaudited) (Note 7)	2009 Actual	2008 Actual
	$	$	$
Revenue			
Ministry of Health and Long Term Care ("MOHLTC") funding	**5,620,413**	**5,590,235**	4,918,431
Health Service Provider ("HSP") transfer payments (Note 8)	**3,980,651,905**	**4,043,555,722**	3,897,601,538
E-Health (Note 9)	**-**	**425,000**	275,000
Emergency Department ("ED") Leads (Note 10)	**-**	**75,000**	37,500
Diabetes Strategy and Diabetes Registry (Note 11)	**-**	**561,500**	-
Aboriginal Health Transition Planning (Note 12)	**-**	**26,625**	-
Emergency Room and Alternate Level of Care (ER/ALC) (Note 13)	**-**	**33,300**	-
Joint Health and Disease (Note 14)	**-**	**-**	358,177
Aging at Home (Note 15)	**-**	**-**	243,000
Wait Times Management (Note 16)	**-**	**-**	70,000
Amortization of deferred capital contributions (Note 5)	**-**	**726,832**	670,268
Amounts recovered/recoverable from the LHINs	**3,900,000**	**3,835,585**	3,697,088
	3,990,172,318	**4,054,829,799**	3,907,871,002
Expenses			
Transfer payments to HSPs (Note 8)	**3,980,651,905**	**4,043,555,722**	3,897,601,538
General and administrative (Note 17)	**5,620,413**	**5,960,266**	5,313,033
LHIN Shared Services Office expense (Note 18)	**3,900,000**	**4,191,836**	3,972,330
E-Health (Note 9)	**-**	**425,000**	275,000
Emergency Department ("ED") Leads (Note 10)	**-**	**75,000**	36,746
Diabetes Strategy and Diabetes Registry (Note 11)	**-**	**561,500**	-
Aboriginal Health Transition Planning (Note 12)	**-**	**26,625**	-
Emergency Room and Alternate Level of Care (ER/ALC) (Note 13)	**-**	**33,300**	-
Joint Health and Disease (Note 14)	**-**	**-**	358,177
Aging at Home (Note 15)	**-**	**-**	243,000
Wait Times Management (Note 16)	**-**	**-**	70,000
	3,990,172,318	**4,054,829,249**	3,907,869,824
Annual surplus before funding repayable to the MOHLTC	**-**	**550**	1,178
Funding repayable to the MOHLTC (Note 4a)	**-**	**(550)**	(1,178)
Annual surplus	**-**	**-**	-
Opening accumulated surplus	**-**	**-**	-
Closing accumulated surplus	**-**	**-**	-

Toronto Central Local Health Integration Network

Statement of changes in net debt

year ended March 31, 2009

	2009	2008
	$	$
Annual surplus	-	-
Acquisition of capital assets	**(478,474)**	(697,643)
Amortization of capital assets	**726,832**	670,268
Change in other non-financial assets	**(26,173)**	4,418
(Decrease) increase in net debt	**222,185**	(22,957)
Opening net debt	**(1,235,730)**	(1,212,773)
Closing net debt	**(1,013,545)**	(1,235,730)

Toronto Central Local Health Integration Network

Statement of cash flows

year ended March 31, 2009

	2009	2008
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**726,832**	670,268
Amortization of deferred capital contributions (Note 5)	**(726,832)**	(670,268)
	-	-
Changes in non-cash operating items		
(Increase) decrease in due from LHINs	**(204,248)**	975,107
Decrease in accounts receivable	-	9,130
Increase in due from MOHLTC regarding HSP transfer payments	**(4,814,106)**	(6,041,877)
Decrease (increase) in due from MOHLTC	**355,037**	(355,037)
Decrease in due from Province of Ontario	-	25,000
(Decrease) increase in accounts payable and accrued liabilities	**(720,691)**	56,067
Increase in due to HSPs	**4,814,106**	6,041,877
Increase (decrease) in due to the MOHLTC	**550**	(1,962)
Increase (decrease) in deferred revenue	**25,950**	(275,000)
(Increase) decrease in prepaid expenses	**(26,173)**	4,418
	(569,575)	437,723
Capital transactions		
Acquisition of capital assets	**(478,474)**	(697,643)
Financing transactions		
Increase in deferred capital contributions (Note 5)	**478,474**	697,643
Net change in cash	**(569,575)**	437,723
Cash, beginning of year	**2,427,507**	1,989,784
Cash, end of year	**1,857,932**	2,427,507

Toronto Central Local Health Integration Network

Notes to the financial statements
March 31, 2009

1. Description of business

The Toronto Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Toronto Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the City of Toronto. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and losses in the value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN financial statements do not include any MOHLTC managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital asset

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year.

2. Significant accounting policies (continued)

Consolidation and segmented financial reporting

The LSSO operations is reported separately from Toronto Central LHIN operations in the schedules accompanying the financial statements and are consolidated in the financial statements of financial position, financial activities, net debt and cash flows.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to (from) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

4. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a. The amount repayable to the MOHLTC related to the current activities is made up of the following components:

	Revenue	Expenses	2009 Surplus	2008
	$	$	$	
Transfer payments to HSPs	4,043,555,722	4,043,555,722	-	-
LHIN operations	5,960,816	5,960,266	550	424
E-Health	425,000	425,000	-	-
ED Leads	75,000	75,000	-	754
Diabetes Strategy and Diabetes Registery	561,500	561,500	-	-
Aboriginal Health Transition Planning	26,625	26,625	-	-
ER / ALC	33,300	33,300	-	-
	4,050,637,963	4,050,637,413	550	1,178

4. Funding rep ayable to the MOHLTC (continued)

b. The amount due from / (to) the MOHLTC at March 31, is made up as follows:

	2009	2008
	$	$
Due to MOHLTC, beginning of year	355,037	(1,962)
MOHLTC payment	(355,037)	-
Funding payable to LHIN by the MOHLTC	-	358,177
Funding repayable to the MOHLTC related to current year activities (Note 4a)	(550)	(1,178)
Due (to)/from MOHLTC, end of year	(550)	355,037

5. Deferred ca pital con tributions

	2009	2008
	$	$
Balance, beginning of year	1,233,677	1,206,302
Capital contributions received during the year	478,474	697,643
Amortization for the year	(726,832)	(670,268)
Balance, end of year	985,319	1,233,677

6. Capital asse ts

			2009	2008
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	251,685	188,780	62,905	113,243
Computer equipment	1,443,394	826,097	617,297	510,201
Leasehold improvements	1,254,543	949,426	305,117	610,233
	2,949,622	1,964,303	985,319	1,233,677

7. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2008. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $4,043,555,722 is made up of the following:

	$
Initial budget	3,980,651,905
Adjustment due to announcements made during the year	62,872,938
Re-allocation between LHINS	30,879
Total budget	4,043,555,722

The total operating budget of $6,741,838 is made up of the following:

	$
Initial budget	5,620,413
Additional funding received during the year for:	
E-Health	425,000
ED Leads	75,000
Diabetes Strategy and Diabetes Registry	561,500
Aboriginal Health Transition Planing	26,625
ER/ ALC	33,300
Total budget	6,741,838

8. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $4,043,555,722 (2008 - $3,897,601,538) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2009 as follows:

	2009	2008
	$	$
Operation of hospitals	**3,172,123,582**	3,071,095,318
Grants to compensate for municipal taxation - public hospitals	**736,800**	736,800
Long term care homes	**224,682,836**	209,617,900
Community care access centres	**169,033,788**	161,321,400
Community support services	**42,425,230**	38,301,330
Assisted living services in supportive housing	**37,916,102**	36,486,300
Community health centres	**66,446,702**	62,469,613
Community mental health addictions program	**86,093,371**	84,791,023
Addictions program	**21,913,442**	21,244,554
Specialty psychiatric hospitals	**222,139,319**	211,492,750
Grants to compensate for municipal taxation - psychiatric hospitals	**44,550**	44,550
	4,043,555,722	3,897,601,538

9. E-Health

The LHIN received funding of $425,000 (2008 - $275,000) related to the E-Health project. E-Health expenses incurred during the year are as follows:

	2009	2008
	$	$
Salaries and benefits	**356,470**	197,981
Consulting	**42,200**	70,000
Other	**26,330**	7,019
	425,000	275,000

10. Emergency Department ("ED") Leads

The LHIN received funding of $75,000 (2008- $37,500) related to the ED Leads project. ED Leads expenses incurred during the year are as follows:

	2009	2008
	$	$
Salaries and benefits	**17,500**	3,300
Consulting	**57,500**	30,000
Other	**-**	3,446
	75,000	36,746

11. Diabetes Strategy and Diabetes Registry

During the year, the LHIN was provided funding of $561,500 (2008 - $Nil) from the MOHLTC for Diabetes Strategy and Diabetes Registry Program. The Diabetes program expenses incurred during the year are as follows:

	2009	2008
	$	$
Salaries and benefits	**528,088**	-
Consulting	**19,250**	-
Other	**14,162**	-
	561,500	-

12. Aboriginal Health Transition Planning

During the year, the LHIN was provided funding of $26,625 (2008 - $Nil) from the MOHLTC for Diabetes and Diabetes referrals Program. The Aboriginal Planning expenses incurred during the year are as follows:

	2009	2008
	$	$
Salaries and benefits	**2,771**	-
Community Forums	**22,915**	-
Other	**939**	-
	26,625	-

13. Emergency Room and Alternate Level of Care (ER/ALC)

During the year, the LHIN was provided funding of $33,300 (2008 - $Nil) from the MOHLTC for the ER/ALC program. The LHIN incurred $33,300 (2008 - $Nil) ER/ALC expenses related to salaries and benefits.

14. Joint Health and Disease

During the prior year, the LHIN was provided funding of $358,177 related to Joint Health and Disease and the LHIN spent $358,177 of this funding on project related expenses. In the current year, the LHIN did not receive similar funding.

15. Aging at Home Strategy

During the prior year, the LHIN was provided funding of $243,000 related to the Aging at Home Strategy project, and the LHIN spent $243,000 of this funding on project related expenses. In the current year, the LHIN did not receive similar funding

16. Wait Times Management

During the prior year, the LHIN was provided funding of $70,000 related to Ontario's Wait Time Strategy, and the LHIN spent $70,000 of this funding on project related expenses. In the current year, the LHIN did not receive similar funding.

17. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2009	2008
	$	$
Salaries and benefits	**3,868,461**	3,360,521
Occupancy	**232,460**	222,349
Amortization	**370,580**	395,026
Shared services	**300,000**	300,000
Public relations	**8,804**	35,626
Consulting services	**711,581**	278,198
Supplies	**110,237**	183,440
Governance	**153,181**	198,709
Mail, courier and telecommunications	**46,041**	46,886
Other	**158,921**	292,278
	5,960,266	5,313,033

18. Common LHIN services expenses

The Statement of Financial Activities presents the common LHIN services expenses by function, the following classifies the same expenses by subject:

	2009	2008
	$	$
Salaries	**980,259**	806,870
Benefits	**182,275**	135,304
Supplies	**15,037**	9,454
Communications	**21,201**	23,396
Recruitment and staff development	**14,346**	12,310
Computer expense	**217,109**	33,254
Consulting fees	**180,587**	76,621
Meeting expenses	**4,124**	2,377
Accommodation and amortization	**428,759**	307,979
Other	**59,925**	20,565
Shared services	**2,088,214**	2,544,200
	4,191,836	3,972,330

19. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 37 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2009 was $301,068 (2008 - $243,358) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2008. At that time, the plan was 97% funded.

20. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, and in accordance with s. 28 of the Financial Administration Act.

21. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due next year and thereafter are as follows:

	$
2010 and thereafter	417,472
	417,472

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2010 and 2011.

22. Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

Toronto Central Local Health Integration Network

Unconsolidated statement of financial position and financial activities of
Toronto Central Local Health Integration Network and Local Shared Services Office - Schedule I
year ended March 31, 2009

	2009	2008	2009	2008	2009	2008
	Toronto Central Operations		Shared Services Office		Total	Total
	$	$	$	$	$	$
Financial assets						
Cash	**665,053**	977,812	**1,192,879**	1,449,695	**1,857,932**	2,427,507
Due from the LHIN Shared Services Office*	**147,296**	127,163	**-**	-	**147,296**	127,163
Due from Local Health Integration Network ("LHIN")	**-**	-	**272,897**	68,649	**272,897**	68,649
Due from Ministry of Health and		-	**-**	-	**-**	-
Long-Term Care ("MOHLTC")	**-**	355,037	**-**	-	**-**	355,037
Due from MOHLTC regarding HSP transfer payments	**10,855,983**	6,041,877	**-**	-	**10,855,983**	6,041,877
	11,668,332	7,501,889	**1,465,776**	1,518,344	**13,134,108**	9,020,233
Liabilities						
Accounts payable and accrued liabilities	**813,875**	1,462,065	**1,318,680**	1,391,181	**2,132,555**	2,853,246
Due to TC LHIN*	**-**	-	**147,296**	127,163	**147,296**	127,163
Due to HSPs	**10,855,983**	6,041,877	**-**	-	**10,855,983**	6,041,877
Deferred revenue	**-**	-	**25,950**	-	**25,950**	-
Deferred capital contributions	**383,149**	753,729	**602,170**	479,948	**985,319**	1,233,677
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**550**	-	**-**	-	**550**	-
	12,053,557	8,257,671	**2,094,096**	1,998,292	**14,147,653**	10,255,963
Net debt	**(385,225)**	(755,782)	**(628,320)**	(479,948)	**(1,013,545)**	(1,235,730)
Non-financial assets						
Prepaid expenses	**2,076**	2,053	**26,150**	-	**28,226**	2,053
Capital assets	**383,149**	753,729	**602,170**	479,948	**985,319**	1,233,677
Accumulated surplus	**-**	-	**-**	-	**-**	-

* Amounts due from the LHIN Shared Services Office and due to TC LHIN is eliminated upon consolidation.

Toronto Central Local Health Integration Network

Unconsolidated statement of financial position and financial activities of
Toronto Central Local Health Integration Network and Local Shared Services Office - Schedule I (continued)
year ended March 31, 2009

	2009		2008	2009		2008	2009	2008
	Toronto Central Operations			Shared Services Office				
	Budget	Actual	Actual	Budget	Actual	Actual	Total	Total
	$	$	$	$	$	$	$	$
Revenue								
Amounts recovered/recoverable from the LHINs*	-	-	-	3,900,000	4,135,585	3,997,088	4,135,585	3,997,088
MOHLTC funding	5,620,413	5,590,235	4,918,431	-	-	-	5,590,235	4,918,431
HSP transfer payments	3,980,651,905	4,043,555,722	3,897,601,538	-	-	-	4,043,555,722	3,897,601,538
E-Health funding	-	425,000	275,000	-	-	-	425,000	275,000
Emergency Department ("ED") Leads (Note 10)	-	75,000	37,500	-	-	-	75,000	37,500
Diabetes Strategy and Diabetes Registry (Note 11)	-	561,500	-	-	-	-	561,500	-
Aboriginal Health Transition Planning (Note 12)	-	26,625	-	-	-	-	26,625	-
Emergency Room and Alternate Level of Care (ER/ALC)	-	33,300	-	-	-	-	33,300	-
Joint Health and Disease (Note 14)	-	-	358,177	-	-	-	-	358,177
Aging at Home (Note 15)	-	-	243,000	-	-	-	-	243,000
Wait Times Management (Note 16)	-	-	70,000	-	-	-	-	70,000
Amortization of deferred capital contributions	-	370,581	395,026	-	356,251	275,242	726,832	670,268
	3,986,272,318	4,050,637,963	3,903,898,672	3,900,000	4,491,836	4,272,330	4,055,129,799	3,908,171,002
								-
Expenses								-
General and administrative (Note 17)	5,620,413	5,960,266	5,313,033	-	-	-	5,960,266	5,313,033
Common LHIN Services*	-	-	-	3,900,000	4,491,836	4,272,330	4,491,836	4,272,330
Transfer payments to HSPs (Note 8)	3,980,651,905	4,043,555,722	3,897,601,538	-	-	-	4,043,555,722	3,897,601,538
E-Health (Note 9)	-	425,000	275,000	-	-	-	425,000	275,000
Emergency Department ("ED") Leads (Note 10)	-	75,000	36,746	-	-	-	75,000	36,746
Diabetes Strategy and Diabetes Registry (Note 11)	-	561,500		-	-	-	561,500	-
Aboriginal Health Transition Planning (Note 12)	-	26,625		-	-	-	26,625	-
Emergency Room and Alternate Level of Care (ER/ALC)	-	33,300		-	-	-	33,300	-
Joint Health and Disease (Note 14)	-	-	358,177	-	-	-	-	358,177
Aging at Home (Note 15)	-	-	243,000	-	-	-	-	243,000
Wait List Management (Note 16)	-	-	70,000	-	-	-	-	70,000
	3,986,272,318	4,050,637,413	3,903,897,494	3,900,000	4,491,836	4,272,330	4,055,129,249	3,908,169,824
Annual surplus before funding surplus repayable	-	550	1,178	-	-	-	550	1,178
Funding surplus repayable to the MOHLTC	-	(550)	(1,178)	-	-	-	(550)	(1,178)
Opening accumulated surplus	-	-	-	-	-	-	-	-
Closing accumulated surplus	-	-	-	-	-	-	-	-

* These amounts have been adjusted by $300,000 related to Toronto Central LHIN transactions. These numbers reflect LSSO operations on behalf of all 14 LHINs.

Local Health Integration Network
Local Shared Services Office

Statement of financial position and financial activities - Schedule II
year ended March 31, 2009

	2009	2008
	$	$
Financial assets		
Cash	**1,192,879**	1,449,695
Due from LHINs	**272,897**	68,649
	1,465,776	1,518,344
Liabilities		
Accounts payable and accrued liabilities	**1,318,680**	1,391,181
Due to TC LHIN	**147,296**	127,163
Deferred revenue	**25,950**	-
Deferred capital contribution	**602,170**	479,948
	2,094,095	1,998,292
Net debt	**(628,320)**	(479,948)
Non-financial assets		
Prepaid Expenses	**26,150**	-
Capital assets	**602,170**	479,948
Accumulated surplus	**-**	-

		2009	2008
	Budget (unaudited)	Actual	Actual
	$	$	$
Revenue			
Amounts recovered/ recoverable from the LHINs*	**4,200,000**	**4,135,585**	3,997,088
Amortization of deferred capital contributions	**-**	**356,251**	275,242
	4,200,000	**4,491,836**	4,272,330
Expenses			
Common LHIN Services	**4,200,000**	**4,491,836**	4,272,330
Annual surplus	**-**	**-**	-

* These amounts have been adjusted by $300,000 related to Toronto Central LHIN transactions. These amounts reflect LSSO operations on behalf of all 14 LHINS.